**STATE OF TENNESSEE**
**DEPARTMENT OF HEALTH**
**HEALTH RELATED BOARDS**
**227 French Landing, Suite 300**
**Heritage Place Metro Center**
**Nashville, TN 37243**
**www.tennessee.gov/health**
OCCUPATIONAL THERAPY
(800) 778-4123 ext 25161OR (615) 532-5161

# APPLICATION FOR CERTIFICATION TO USE PHYSICAL AGENT MODALITIES

1. Complete, sign, and have notarized the application pages 1-6.

2. Have verification of successful completion of training (Attachment 1 and/or Attachment 2) sent directly to the Committee from ALL training providers; or if applying by Certification as a Hand Therapist have certification sent to the Committee directly from the certifying body.

| Certification Alternatives | Educational Method – Check all that apply |
|---|---|
| _____ Electrical Stimulation Certification | _____ Courses taken prior to 10/14/00 |
| _____ Thermal Agents Certification | _____ Committee Pre-Approved Courses |
| _____ Both Certifications | _____ Certified Hand Therapist |

## PERSONAL INFORMATION

PLEASE PRINT IN INK

Name _____
Last First Middle/Maiden

Social Security Number _____-_____-_____ Date of Birth _____

Mailing Address _____ License Number _____

_____ Phone: Home _____

_____ Office _____

CONTENT DOCUMENTATION
Electrical Stimulation Certification

The Occupational Therapy Rules require 25 hours of didactic and laboratory experiences which include five treatments on clinical patients to be supervised by licensees who hold certification or by a physical therapist.

Please list courses/programs. For each, indicate the total number of hours that you would like the Committee to consider, the number of hours to be counted toward the specific content requirements, and the topic areas that were covered in each course/program. Use the letters of the following list to identify required topics.

A. Standards – topic must include: 1) The expected outcome or treatments with therapeutic electrical current (TEC) must be consistent with the goals of treatment; 2) Treatment of TEC must be safe, administered to the correct area, and be of proper dosage.

B. Correct dosage and mode – topics must include: 1) Ability to determine the duration and mode of current appropriate to the patient's neurophysiological status while understanding Ohm's law of electricity, physical laws related to the passage of current through various media, as well as impedance; 2) Ability to describe normal electrophysiology of nerve and muscle; understanding generation of bioelectrical signals in nerve and muscle; retirement of motor units in normal muscle and in response to a variety of external stimuli; 3) Ability to describe normal and abnormal tissue responses to external electrical stimuli while understanding the differing responses to varieties of current duration, frequency and intensity of stimulation.

C. Selection of method and equipment – topics must include: 1) Ability to identify equipment with the capability of producing the pre-selected duration and mode; 2) Ability to describe characteristics of electrotherapeutic equipment; 3) Ability to describe safety regulations governing the use of electrotherapeutic equipment; 4) Ability to describe principles of electrical currents; 5) Ability to describe requirements/idiosyncrasies of body areas and pathological conditions with respect to electrotherapeutic treatment.

D. Preparation of treatment – topics must include: 1) Ability to prepare the patient for treatment through positioning and adequate instructions; 2) Ability to explain to the patient the benefits expected of the electrotherapeutic treatment.

E. Treatment administration – topics must include: 1) Ability to correctly operate equipment and appropriately adjust the intensity and current while understanding rate of stimulator, identification of motor points, and physiological effects desired; 2) Ability to adjust the intensity and rate to achieve the optimal response, based on the pertinent evaluative data.

F. Documentation of treatments – topic must include: 1) Ability to document treatment including immediate and long-term effects of therapeutic current.

**ELECTRICAL STIMULATION CERTIFICATION**
**CHECK TOPICS INCLUDED**

| Course Title | # Total Hours | # Specific Hours | A1 | A2 | B1 | B2 | B3 | C1 | C2 | C3 | C4 | C5 | D1 | D2 | E1 | E2 | F1 | # of TX |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
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| Neuromuscular Electrical Stimulation Treatment | | | | | | | | | | | | | | | | | | |
| Electrical Stimulation for Pain Control Treatment | | | | | | | | | | | | | | | | | | |
| Edema reduction Treatment | | | | | | | | | | | | | | | | | | |
| Iontophoresis Treatment | | | | | | | | | | | | | | | | | | |
| Total | | | | | | | | | | | | | | | | | | |

Attach additional sheets if necessary

1. **Please check to be sure that each topic was covered at least once, that you have included at least 25 hours of specific content requirements and treatment requirements**
2. **Enclose course outlines/syllabus if course is not pre-approved by the committee**
3. **Enclose proof of completion of course (attachment 1 and 2)**

CONTENT DOCUMENTATION
Thermal Agents Certification

The Occupational Therapy Rules require twenty (20) hours of didactic and laboratory experiences which include ten treatments on clinical patients to be supervised by licensees who hold certification or by a physical therapist.

Please list courses/programs. For each, indicate the total number of hours that you would like the Committee to consider, the number of hours to be counted toward the specific content requirements, and the topic areas that were covered in each course/program. Use the letters of the following list to identify required topics.

A. Standards – topics must include 1) The expected outcome or treatments with thermal agents must be consistent with the goals of treatment; 2) Treatment with thermal agents must be safe, administered to the correct area, and be the proper dosage; 3) Treatment with thermal agents be adequately documented.

B. Instrumentation – topics must include 1) Ability to describe the physiological effects of thermal agents as well as differentiate tissue responses to the various modes of application; 2) Ability to select the appropriate thermal agent considering the area and conditions being treated; 3) Ability to describe equipment characteristics, indications, and contraindications for treatment, including identifying source and mechanisms of generation of thermal energy and its transmission through air and physical matter.

C. Preparation for treatment- topics must include 1) Ability to prepare the patient for treatment through positioning and adequate instruction; 2) Ability to explain to the patient the benefits expected of the thermal treatment.

D. Determination of dosage – topic must include 1) Ability to determine dosage through determination of target tissue depth, stage of the condition (acute vs. chronic), and application of power/dosage calculation rules as appropriate.

E. Treatment administration – topic must include 1) Ability to administer treatment through identification of controls, sequence of operation, correct application techniques and application of all safety rules and precautions.

F. Documentation of treatments – topic must include 1) Ability to document treatment including immediate and long-term effects of thermal agents.

**THERMAL AGENTS CERTIFICATION**
**CHECK TOPICS INCLUDED**

| Course Title | # Total Hours | # Specific Hours | A1 | A2 | A3 | B1 | B2 | B3 | C1 | C2 | D1 | E1 | F1 | # of TX |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
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| Superficial heating agents | | | | | | | | | | | | | | |
| Cryotherapy | | | | | | | | | | | | | | |
| Deep Heating Agents | | | | | | | | | | | | | | |
| Total | | | | | | | | | | | | | | |

Attach additional sheets if necessary

1) **Please check to be sure that each topic was covered at least once, that you have included at least 20 hours of specific content requirements and treatment requirements**
2) **Enclose course outlines/syllabus if course is not pre-approved by the committee**
3) **Enclose proof of completion of course (attachment 2)**

## AFFIDAVIT AND RELEASE

I, _____, of _____, being
NAME CITY/STATE

and identified as the person referred to in this application, attests to the truth of such statement made in said application.

I HEREBY:

**SIGNIFY**, my willingness to appear to answer such questions as the Committee may find necessary which may include a Committee interview.

**RELEASE** to the Committee, its staff and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safety practice Occupational Therapy.

**AUTHORIZE** the Committee, its staff and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualification, ability to work cooperatively with others and other qualifications;

**RELEASE** from liability the Committee, its staff and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character and other qualifications for certification.

**ACKNOWLEDGE** that I, as an applicant for certification, have the burden of producing adequate information for a proper evaluation of my professional, ethical and other qualifications and for resolving any doubts about such qualifications.

**THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.**

_____ _____
SIGNATURE DATE

Sworn to before me, this _____ day of _____, 20 _____.

_____ Affix Seal Here
NOTARY PUBLIC

My Commission Expires _____

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Attachment 1

TENNESSEE COMMITTEE OF OCCUPATIONAL THERAPY

DOCUMENTATION OF CONTINUING EDUCATION
**ELECTRICAL STIMULATION CERTIFICATION**

LICENSEES NAME: _____ LIC# _____

PROGRAM TITLE: _____

PROGRAM PRESENTER: _____

CREDENTIALS: _____

LOCATION OF PROGRAM: _____

DATE: _____ TOTAL CONTACT HOURS: _____

PROGRAM OUTLINE AND DESCRIPTION –
Please attach course outline if this is not a pre-approved program.

| CLINICAL TREATMENTS – ENTER NUMBER PERFORMED | TREATMENT TIME |
|---|---|
| _____ Neuromuscular electrical stimulation | _____Nueromuscular Electrical Stimulation |
| _____ Electrical stimulation for pain control | _____Electrical Stimulation for Pain Control |
| _____ Edema reduction | _____Edema Reduction |
| _____ Iontophoresis | _____Iontophoresis |

HAS PROGRAM BEEN PRE-APPROVED BY THE COMMITTEE? _____

_____ _____
Signature of Licensee Date

I hereby certify that the above name individual has successfully completed the above program and treatments as indicated.

_____ _____ _____ _____
Signature Title License # Date

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Attachment 2

TENNESSEE COMMITTEE OF OCCUPATIONAL THERAPY

DOCUMENTATION OF CONTINUING EDUCATION
**THERMAL AGENTS CERTIFICATION**

LICENSEES NAME: _____ LIC #: _____

PROGRAM TITLE: _____

PROGRAM PRESENTER: _____

CREDENTIALS: _____

LOCATION OF PROGRAM _____

DATE: _____ TOTAL CONTACT HOURS: _____

PROGRAM OUTLINE AND DESCRIPTION –
Please attach course outline if this is not a pre-approved program.

| CLINICAL TREATMENTS – ENTER NUMBER PERFORMED | TREATMENT TIME |
|---|---|
| _____Superficial Heating Agents | _____Superficial Heating Agents |
| _____ Cyrotherapy | _____ Cyrotherapy |
| _____Deep heating agents | _____Deep heating agents |
| _____Number of the above treatments utilizing ultrasound | |

HAS PROGRAM BEEN PRE-APPROVED BY THE COMMITTEE? _____

_____ _____
Signature of Licensee Date

I hereby certify that the above name individual has successfully completed the above program and treatments as indicated.

_____ _____ _____ _____
Signature Title License # Date

LP/G5030206/OT